MEMORANDUM

DATE: April 27, 2007

TO: Mr. Michael J. Rich, DAG
c/o Department of Insurance

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 10 DE Reg. 1523 [MCO Appeal Regulations]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Insurance's (DOI) proposal to adopt a wholesale revision to it regulations covering review and appeal of MCO decisions. The regulations were published as 10 DE Reg. 1523 in the April 1, 2007 issue of the Register of Regulations. SCPD understands that the impetus for the new regulations is S.B. 295 which was signed by the Governor on July 6, 2006. S.B. 295 transferred regulatory authority over HMOs/MCOs previously vested in the Department of Health and Social Services (DHSS) to the Department of Insurance.

SCPD submitted comments on an earlier version of these proposed regulations in February, 2007. The latest version of the proposed regulations are almost identical to the February version with the following exceptions: 1) Section 16.0 contains different effective dates; 2) a new Section 7.4 has been added imposing a carrier and provider duty to arbitrate emergency care fee disputes; and 3) Section 7.3 has been modified in the context of emergency care services payment standards. To this end, none of the changes recommended in the Councils' earlier comments have been addressed. SCPD has the following observations consistent with our February 22, 2007 memorandum.

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First, the insured can assign a claim to a health care provider who can then pursue "appeals" with the insurer. See definition of "authorized representative" in Section 2.0. This is similar in effect to H.B. 438 which passed the House but not the Senate in 2006. SCPD endorsed that bill.

Second, in Section 2.0, the definition of "health care service" could be improved. It covers "services and supplies". This may not cover denials of durable medical equipment (DME) or assistive technology (AT - e.g. nebulizer, hearing aid, wheelchair; AAC device). Cf. reference to "products" in definition of "medical necessity" in Section 2.0. The Legislature contemplated reviews of denials of "devices". See reference to "device" in Title 18 Del.C. §6417(c)(3)e (as amended by S.B. 295).

The DOI should consider inclusion of references to both DME and AT (defined at 29 U.S.C. §3002).

Third, in Section 2.0, the definition of Independent Utilization Review Organization (IURO)"omits the term "reduction" which is explicitly included in the definition of "adverse determination". It should be included for consistency.

Fourth, in Section 2.0, the definition of "medical necessity" should be amended to include "disability" and "condition". There are health conditions (e.g. cerebral palsy; pregnancy) that may require medical services but are not diseases or illnesses. Compare definition of "health care services" in Section 2.0 which includes a reference to "disability". See also reference to "disability" in definition of "health care services" in Title 18 Del.C. §6403(d) (as amended by S.B. 295). Cf. reference to "condition" in Section 9.1.

Fifth, although the list of professionals within the definition of "provider" in Section 2.0 is not exclusive, it would be preferable to include some mental health related practitioners who are commonly included in health care networks (e.g. licensed psychologist; LCSW).

Sixth, Section 3.1.1 could be improved by substituting 12 point type for 11 point type.

Seventh, Section 3.1.2 could be improved by proscribing use of italicized type which is generally more difficult to read than "block" styles.

Eighth, the regulations do not address maintenance of services during the pendency of reviews and appeals. This is generally viewed as a matter of basic due process. Compare 16 DE Admin Code 5100, §5308; 42 C.F.R. §431.231.230 (Medicaid); and Title 14 Del.C. §3143. At a minimum, the regulations could require continuation of services during expedited reviews of imminent and serious threats within the purview of Section 9.1. The discontinuation of such services could be life-threatening.

Ninth, coverage of Medicaid MCOs is unclear. Section 5.5 suggests that the arbitration and IHCAP systems do not apply to Medicaid MCOs. Based on "inclusio unius, exclusio alterius", this would suggest that mediation in Section 4.0 is available to review Medicaid MCO disputes. This should be clarified. Parenthetically, S.B. 295 did not exclude Medicaid MCOs from its scope [Title 18 Del.C. §6403(e)] and it would be preferable to apply the consumer protections in the regulations to Medicaid MCOs unless they actually conflict with Medicaid protections. For example, a mediation system could supplement and not supplant a right to a Medicaid administrative hearing.

Tenth, it would be preferable to include an authorization for an "in forma pauperis" application to waive (in whole or part) the $75 fee for arbitration otherwise required by Section 6.1.3.3. There may be indigent consumers who will lack the financial wherewithal to pay $75 to contest an insurance denial. The Department would then have to determine whether the $75 fee would be waived or imposed on the insurer. See Section 6.7.1. By analogy, the insurer pays all costs of an IHCAP review. See Section 11.1.

Eleventh, Sections 14.1 and 14.2 protect a "covered person" and "provider" from retaliation. It would be preferable to also include the covered person's employer if there is an employer-based

group policy. Otherwise, the insurer could retaliate against the employer (e.g. through non-renewal of policy).

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations on the proposed regulation.

cc: The Honorable Matthew Denn
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

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